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Nature versus nurture segues to choice versus circumstance in the new millennium: one consideration for an integrative biopsychosocial philosophy, art, and science of chiropractic

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Abstract

Objective: This commentary discusses the evolving sociocultural roles and sociocultural authority of chiropractic.

Discussion: The complex interconnectivity of the biological, psychological, and social aspects of our individual and collective well-being has occupied centuries of "nature versus nurture" philosophical debate, creative art, and scientific work. What has emerged is a better understanding of how our human development is affected by the circumstances of what we are born with (ie, nature) and how we are shaped by the circumstances that we are born into (ie, nurture).

Conclusion: In the new millennium, a cumulative challenge to the emerging integrative biopsychosocial health care disciplines is one of reconciling "circumstance versus choice"; that is, advancing individually and collectively the fullest actualization of human potential through the philosophy, art, and science of autonomy and empowerment.

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Introduction

In this commentary, I present information and encourage further inquiry and dialogue regarding the separate but related concepts of sociocultural roles and sociocultural authority of chiropractic. Perhaps most importantly, I suggest that our fundamental underlying assumptions about the notion of "sociocultural authority" may warrant careful studied consideration. Rather than conceive superficially that sociocultural authority is solely a macro-level collective characteristic attributed to an entire profession, it may be more helpful and accurate to consider the concept of sociocultural authority as being multidimensional and multilevel. Sociocultural authority and sociocultural roles are neither predetermined nor static, but include dynamic micro-level processes of malleable factors such as shifting perceptions and evolving relationships between individuals, as well as macro-level interactions between collective entities.

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Recent scholarly attention focuses laudably on better understanding and appreciating the full diversity of chiropractic patients and their biological, psychological, and sociocultural needs and circumstances. We need to stay mindful that successful development of a comprehensive biopsychosocial approach toward actualizing the full potential for chiropractic health care provision and integrative health care delivery should explicitly recognize the priority and value of individual preferences and choice in matters of health and health care.

Framing the discussion

I borrow loosely from the academic traditions of sociology and anthropology to provide a general orienting framework for the following discussion. From the general perspective of structural functionalism in sociology, the chiropractor-patient relationship can be viewed as an interaction between autonomous individuals while explicitly recognizing the importance of contextual factors such as physical or social constraints that may also influence the actions of the individuals and the interactions between them. Multiple interactions and repeated behaviors may create normative social "roles" for each of the participants in such interactions, as their respective expectations become more entrenched or institutionalized over time. Roles are malleable, that is, autonomous individuals in new interactions with changing situations may adapt through processes such as "role bargaining," thereby establishing new roles and new norms that may, in turn, initiate or guide further action. Roles and collectivities of roles (ie, roles that complement each other in fulfilling functions for society) can be considered "structural" in the sense that they may manifest as institutions or social structures, such as social arrangements with proscribed economic or legal parameters. Individual and collective roles can be considered "functional" in relation to operative processes such as social change. That is, individuals and collective entities may develop new values that legitimate a greater range of activities as a new social order, thereby creating new functional alternatives to the institutions and structures currently fulfilling the functions of society.

Sociocultural anthropology, drawing from the combined historical traditions of cultural anthropology's focus on symbols and values and social anthropology's focus on social groups and institutions, generally promotes the idea of "cultural relativism" (ie, the view that one can only understand another person's beliefs and behaviors in the context of the culture in which he or she lived or lives). Emerging anthropological methods such as multisited ethnography introduce interdisciplinary approaches to fieldwork by incorporating methods from cultural studies, media studies, science and technology studies, and others. Tracking subjects across spatial and temporal boundaries, such research combines a focus on the local with an effort to grasp larger political, economic, and cultural frameworks that impact local lived realities in order to gain greater insights by examining the impact of higher-order "systems" on local communities, specific populations, or individuals. Such qualitative, encompassing, exploratory approaches have obvious potential utility for illuminating complex, multidimensional, multilevel notions such as dynamic sociocultural roles of chiropractors or the evolving sociocultural authority of the chiropractic profession.

Sociocultural roles

Sociocultural roles are multidimensional, even within a presumably narrow context such as health care provision. For instance, the disciplinary roles of most health care professionals are typically developed in disciplinary isolation during their pregraduate education and training, such that nurses in nursing school are educated separately from medical physicians in medical school. Without adequate preparation, new clinical practitioners "may transition to the workplace unprepared for collaboration at a time when chronic illnesses require the concerted effort of coordinated, fully cooperative health care teams".[1]

Innovations such as interdisciplinary clinical training programs encourage clinical trainees to explore the terrain of adapting their singular disciplinary roles to fit the actual exigencies of clinical practice; for example, their clinical roles. In other words, disciplinary roles and clinical roles are 2 distinct, though related, concepts. The necessary transition and negotiation between singular disciplinary role and interdisciplinary clinical role may require a substantial commitment, willingness, and ability to explore issues of role if potential clinical collaborations are to be effective, mutually satisfying, and actualized.[1,2]

Disciplinary roles may be considered structural in the sense that they are largely shaped during standardized credentialing processes, such as disciplinary-specific education in accredited health professions institutions that prepare and qualify the individual to meet proscribed legal requirements to obtain professional licensure and

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